

MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

The Horizon Ballroom
Ronald Reagan Building
International Trade Center
1300 Pennsylvania Avenue, N.W.
Washington, D.C.

Wednesday, January 15, 2003

9:30 a.m.

COMMISSIONERS PRESENT:

GLENN M. HACKBARTH, Chair
ROBERT D. REISCHAUER, Ph.D., Vice Chair
SHEILA D. BURKE
AUTRY O.V. "PETE" DeBUSK
NANCY ANN DePARLE
DAVID DURENBERGER
ALLEN FEEZOR
RALPH W. MULLER
ALAN R. NELSON, M.D.
JOSEPH P. NEWHOUSE, Ph.D.
CAROL RAPHAEL
ALICE ROSENBLATT
JOHN W. ROWE, M.D.
DAVID A. SMITH
RAY A. STOWERS, D.O.
MARY K. WAKEFIELD, Ph.D.
NICHOLAS J. WOLTER, M.D.

AGENDA ITEM:**PAGE**

Assessing payment adequacy and updating Medicare payments

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 - Ariel Winter

MR. HACKBARTH: Kevin, would you lead the way?

DR. HAYES: Sure. We went over this issue, as you said, at the December meeting and the staff's perception was that there was general agreement about our findings on payment adequacy and general agreement with the recommendation. There were a few questions, though, about some related issues and I just wanted to spend a second or two on those, the first one having to do with participation agreements.

Your concern was that we might see a drop-off in physician participation in Medicare in 2003 given the scheduled 4.4 percent reduction in the fee schedule's conversion factor. Indeed, if there is a drop-off, that would be a distinct break from the trend. As you can see here, participation rates has been climbing steadily. This is a trend that's been going on since the late '80s. But just in this most recent experience the participation rate has gone up from about 80 percent to close to 90 percent.

As to what we know about participation in 2003, it's really too early to tell. The rates for 2003 were not published until December 31st. Enrollment materials were sent out to physicians starting on January 2nd, so we're talking now about two weeks ago.

Given the level of concern about this issue however, I did call a few of the carriers and track down the enrollment coordinators with them and they confirmed that yes, indeed, it's just too early. In the case of Northern California, they had received enrollment materials from five physicians, I think. In Pennsylvania it was 11, similar experiences.

So all we can say at this point is that physicians have not flooded the carriers with enrollment materials indicating that they are no longer going to accept assignment. That didn't happen right away, which is kind of a nightmare scenario, but that's all we can say at this point.

I was going to say a few things about professional liability insurance premiums and how they've changed over time in response to questions that came up at the last meeting, but I don't have anything to say here that was not in the paper that was sent out. So if you've got questions about this we can come back to it but

I won't spend any time on it now.

And then we can just move on to the recommendation which is what we presented at the December meeting, which is that the Congress should update payment for physician services by the projected change in input prices, less an adjustment for productivity growth, currently estimated at 0.9 percent. The current estimate on the change in input prices is 3.4 percent for 2004, so the net update would be 2.5 percent.

This would be greater than current law. The current law update for physician services for 2004 is an update of minus 5.1 percent. So we are certainly talking about an increase in spending here. We estimate that that would be in the category of greater than \$1.5 billion in that year, 2004. That's it.

MR. HACKBARTH: Comments?

DR. NELSON: Thank you, Kevin, for some of the additional material that was included in here, including the further description about the participation process. And also a good discussion on the behavioral offset. I appreciate that.

Glenn, is it possible to -- are we restricted to one sentence recommendations? Because if we are not -- [Laughter.].

MR. HACKBARTH: If we are, we violated earlier this morning.

DR. NELSON: If we are not, I'd be much more comfortable -- if indeed our recommendation included an additional sentence which is on page one, it's the last sentence in the pull-out paragraph. It says if the Congress does not change current law higher update may be necessary in 2004 to offset the negative update in 2003.

Now I'm happy with it being in the pull-out but it's such an important consideration and played such an important role in our earlier discussion, that I'd be more comfortable if that caveat were included with the recommendation.

MS. BURKE: I don't disagree substantively with what you're saying, Alan, but I worry about putting it as part of a recommendation which is a specific action. And this is sort of well, if you don't, X will occur.

I wonder if there isn't a way to make that statement a much more direct one and a forceful one in the context of the text rather than literally as part of the recommendation. I don't disagree with where you want to go, I'm just not sure I understand how it fits into a recommendation.

DR. NEWHOUSE: Additional recommendation.

MS. BURKE: Well, is it?

MR. HACKBARTH: If you don't do it now, then do it in 2004.

MS. BURKE: That's not what he said. What he said was -- what I understand Alan to be -- well, then that's different than what I heard. Then I misheard you.

If we were specifically saying this update is what we recommend, if you don't do this update then we're recommending X update next year. That's different from what I heard.

MS. DePARLE: I think that's what you meant to say.

DR. NELSON: I think that's what I meant to say, Joe, and I'm happy if it's a second recommendation. And it may be that it's not necessarily but I think that it is, at present, in a very conspicuous part of the text. It's not that we're burying it. But a lot of times members of Congress just read the recommendation and they will read the recommendation as though that's just fine, and it's not just fine if there's a negative update this year. It's far from fine.

MS. BURKE: It's an interesting question in scoring. Just as a side note -- and Bob, maybe you'll have some sense of this. If we literally -- I mean, we are looking at what the implications would be. We know it will increase spending by such amount. Were we to say do it now, if you don't do it now, we're doing it double time next time. I assume they start tracking -- I mean, it's an odd convenience to sort of do two year's worth of recommendations in a year's recommendations.

MR. HACKBARTH: The reason that I prefer, Alan, doing it in the text is, number one, we made the 2003 recommendation once. This is a package of 2004 recommendations.

All indications are that Congress is grappling with the 2003 issue. I don't think we need to take out a megaphone and yell at them about it. They understand that this is an issue that at least they need to deliberate on. How they will end up, I don't know.

So I would prefer to, consistent with every other chapter in this book, focus on the recommendation, but clearly at a prominent place establish the context for that. And it's in the context of our 2003 recommendation.

DR. NELSON: I bow to your wisdom.

MR. HACKBARTH: Thank you. Any other comments on this?

MR. DURENBERGER: I just want to compliment the analysts for introducing the subject of volume growth, which in my mind relates to the intensity and some of these kinds of issues, and the lead up to it in various subspecialties and in radiology and so forth, which strikes me as being a very important reality that we can't quite put our heads around. And very appropriately it says MedPAC is currently conducting research on this issue, which I think is a very, very important piece of work and I compliment them on doing it.

MR. HACKBARTH: As I recall, our objective is have some of that work for the June report; is that right?

Any other comments on this?

DR. WOLTER: Yes, just for clarification. Is the recommendation that we're looking now predicated on the possibility that last year's recommendation would possibly occur as Congress readdresses this? Because that could happen, there could be an elimination of the cut but a freeze at current rates. Or nothing could happen. And although the language here does generally talk about some compensating change, it's a little bit unclear to me what that might mean.

MR. HACKBARTH: I think you're touching on the same concern

that Alan had. As you'll recall, last year -- actually, Nick, you wouldn't recall because you weren't on the commission last year. Our recommendation last year had two parts basically for physician services. One was repeal of the SGR system. And then the second was to replace it with an update based on a revised MEI minus a productivity factor.

To this point all indications are that Congress has not embraced repeal of SGR, but they are looking at options for modifying the result of the SGR system for fiscal year 2003, namely the 4.4 percent cut.

Again, how that turns out, I don't think there's anybody that knows at this point. Whether it's a 2.5 percent update or a freeze is really anybody's guess.

That is why we wanted to go on record in the text as saying we're recommending this in 2004 and we think at least a modest increase in fees would have been appropriate for 2003, and trying to remove that ambiguity. But for the reasons I just gave Alan my preference would be to have the bold-faced recommendation focused just on 2004 and have the other matter dealt with in the text.

I had one question about the language, Kevin. It says less an adjustment for productivity growth, currently estimated at 0.9 percent. For physician services and all other services, we're using the long-term trend in multifactor productivity in the economy in general. We're not trying to measure physician productivity. I think MedPAC, at one point, used to use the term -- it was like a policy adjustment factor or something like that, as opposed to an estimate of actual productivity.

Some people might construe the language here as we're trying to estimate the change in physician productivity. So what I would suggest is just say less an adjustment for productivity growth of 0.9 percent to avoid that confusion.

Did that come through clearly and do people agree with that?

Okay, are we ready to vote on the revised recommendation then? All those in favor?

Opposed?

Abstain?

Thanks, Kevin. Next up is outpatient dialysis. Nancy, again, I'd appreciate your help in trying to move through this as quickly as possible.

* MS. RAY: I'll do what I can.

This is the last in the series of three presentations that you've seen on assessing payment adequacy and updating payments for outpatient dialysis services. I'll focus on any new information, as well as any changes from my presentation last month.

Moving right along, staff used 2001 cost report data as the first step in estimating current costs for 2003. As we've done for the last several years, we consider separately billable drugs as well as composite rate services. However, for the first time this year our analysis does account for the fact that the most

current year that we have the data, 2001, that that data has not yet been audited. MedPAC's analysis of providers cost is based on Medicare allowable costs.

Our analysis of the most recent year for which cost report data are available, that's 1996, shows that allowable cost per treatment for composite rate services for freestanding facilities averaged about 95.7 percent of the reported treatment costs. Therefore, taking that into effect, the average payment-to-cost ratio across freestanding facilities, including separately billable drugs and composite rate services is 1.04. Considering just composite rate services, the payment-to-cost ratio is 0.97.

Then to estimate current payments and costs for 2003, how we did this is in your briefing materials and we went into this in greater depth last month. So our protection shows that for 2003, the payment-to-cost ratio would decline by no more than 3 percentage points lower than the 2001 level. Again, this assumes current law, provides for no change in the composite rate payment for 2002, 2003 or 2004.

We looked at market factors, and again those are described at great length in your briefing materials, and they suggest payments are at least adequate. The information on the next three slides is what you've seen before, in terms of the growth and the capacity to furnish dialysis, in terms of the increasing number of freestanding dialysis facilities, as well as the increase in the number of for-profit facilities.

So we now go to our second step in MedPAC's framework where we project increases in providers' costs in the next payment year. Based on MedPAC's dialysis marketbasket index, we estimate that input prices will rise by 2.5 percent between 2003 and 2004. This number did change from what you saw last month, which was 2.7 percent because we got in the latest information from CMS in the interim. So MedPAC's dialysis marketbasket index projects input prices will rise 2.5 percent between 2003 and 2004.

MedPAC's framework does consider other factors that affect providers' cost in the next payment year. Staff conclude that most medical advances will be accounted for through the payments for separately billable drugs and for productivity improvements we again use the multifactor productivity standard that the other provider groups are using which is 0.9 percent.

Therefore, staff have drafted this recommendation based on the conclusion that staff judge that payments are at least adequate, that the dialysis marketbasket as developed by MedPAC shows that costs will increase by 2.5 percent and the draft recommendation reads for calendar year 2004 the Congress should update the composite rate by the projected change in input prices less 0.9 percent. The budget implication for that, relative to current law, we estimate that for one year it will be in the category of \$50 million to \$200 million and in the category of \$250 million to \$1 billion over five years.

MR. HACKBARTH: Comments? This is unprecedented.

DR. REISCHAUER: Jack Rowe isn't here.

MR. HACKBARTH: We're ready to vote, I guess. All in favor of the recommendation?

Opposed?

Abstain?

Thanks, Nancy

The last item before lunch is ambulatory surgical facilities.

* MR. WINTER: Good morning. First, I will present a new draft recommendation related to the collection of ASC cost data. I will then briefly review our assessment of payment adequacy for ASC services, and our draft recommendation for updating ASC payment rates. Next, I'll discuss our analysis of the mix of patients who receive procedures in ASCs and hospital outpatient departments. Finally, I'll review our draft recommendation to limit ASC payment rates to hospital outpatient rates and discuss the impacts of this recommendation.

Current ASC payment rates are based on a 1986 survey of ASC costs and charges. The secretary is required to conduct a new survey of ASC costs and charges every five years. In 1998, CMS proposed restructuring the ASC payment system based on data from the 1994 cost survey. This proposal would have reduced payment rates for high volume procedures, such as cataract-related surgeries and colonoscopies. However, the Congress required CMS to delay the new payment system and to base new rates on cost survey data from 1999 or later.

To our knowledge, CMS has not conducted a new survey since 1994. Thus, we propose recommending that the secretary expedite the collection of ASC charge and cost data for the purpose of analyzing and revising the ASC payment system. Once it is collected, recent cost data also would be used for our assessment of the adequacy of ASC payments. This recommendation would have no impact on spending on Medicare benefits.

Because we lack recent data on ASC costs, we look at market factors in judging payment adequacy. Here is a quick review of those factors which we discussed in more detail last month. In the interest of time, I won't go through them in more detail but you can ask me about them if you have questions.

Briefly, though, we looked at rapid growth in the number of ASCs. We also observed rapid growth in the volume of procedures they provide to Medicare beneficiaries. We also note that there is strong access to capital for ASC facilities. These market factors lead staff to conclude that current Medicare payments to ASCs are more than adequate.

We also considered expected increases in ASC's costs in the coming year, and concluded that current payments are at least adequate to cover this increase in costs.

Thus, we propose recommending that the Congress eliminate the update to payment rates for ASC services for fiscal year 2004. Under current law, payments would be updated by the increase in the CPIU, which is currently projected to be 2.7 percent for 2004. We estimate that this recommendation would

reduce spending in the category of less than \$50 million in fiscal year 2004 and in the category of less than \$250 million between fiscal years 2004 and 2008.

At the last few meetings, we've also discussed the issue of ASC payment rates that exceed outpatient hospital rates for the same procedure. This table compares rates in each setting for the five procedures with the highest share of Medicare payments to ASCs. We've been through this before so I'm not going to go through this in more detail right now.

The commission has expressed concern that payment variations by setting that are unrelated to cost differences could create financial incentives to shift services from one setting to another. We lack evidence that ASC costs are higher than outpatient department costs, which would justify higher ASC rates.

One factor that would affect costs in each setting is regulatory requirements and outpatient departments face more requirements than ASC. For example, hospitals are subject to the Emergency Medical Treatment and Labor Act, which requires outpatient departments to stabilize and transfer patients who believe they are experiencing a medical emergency, regardless of their ability to pay. This law does not apply to ASCs.

We have also hypothesized that, compared to ASCs, outpatient departments serve beneficiaries who are more medically complex and thus likely more costly to treat. To test this hypothesis, we used Medicare claims data to compare the characteristics of beneficiaries who use ASC services versus those who use outpatient department services. First, we compared the average risk scores of fee-for-service beneficiaries who received surgical services in each setting. The risk scores were derived from the hierarchical condition category risk adjustment model. They predict beneficiaries' expected service use in 1999 given their health status relative to that of the average beneficiary. Expected use is based on the beneficiary's age, sex, and diagnoses from inpatient, outpatient and physician visits during 1998.

This table compares average risk scores for beneficiaries who received similar types of procedures in an ASC or outpatient department. The five procedure categories shown here represent the highest volume ASC categories. Each category consists of several related procedures, whereas the procedures listed on slide five, two slides earlier, are at the individual level. It is important to control for procedure type because the mix of surgical procedures differs between ASCs and outpatient departments and higher risk patients are associated with certain procedures.

Keeping in mind that the average beneficiary in Medicare has a risk score of one, you'll notice that beneficiaries in both settings had higher risk scores than the average Medicare beneficiary, and were thus more medically complex. Across these categories, risk scores were uniformly higher for beneficiaries

who received care in outpatient departments than those who were treated in ASCs. The percent difference between outpatient and ASC risk scores ranges from 3 percent for patients who received cataract removal to 10 percent for patients who had upper GI endoscopy. This indicates that outpatient department patients were more medically complex than patients in ASCs, which probably means they were more costly to treat.

Since these numbers were calculated, we have been reviewing our methodology and have revised it to better account for part-year Medicare enrollees. We do not yet have results for the new methods. However, we believe that the new method will affect the results in two ways. It will move the risk scores closer together for the first four procedure categories shown here which account for 71 percent of ASC volume, but the outpatient scores will still be higher and the difference will still be statistically significant.

For the last category, which accounts for 13 percent of volume, and that's ambulatory procedures other, the risk scores should move closer together but may no longer be different in a statistically significant way.

Next, we compared total Medicare payments for all services in 1999, for fee-for-service beneficiaries who receive procedures in an ASC or outpatient department. Total payments represent spending on all the services used by the beneficiary, including ambulatory care, inpatient care, and post-acute care. Total spending could reflect beneficiaries' health status. We'd expect utilization to increase as health status declines. However, other factors could also affect total payments, such as supplemental coverage and local practice patterns. Thus, these are a less direct measure of health status than the risk scores.

This table compares total payments, average total payments for beneficiaries in ASCs and outpatient departments who receive similar types of procedures. And just to walk you through this a little bit, the top row, cataract removal, the number there represents total spending by Medicare on patients who received that procedure in an ASC versus an outpatient department.

Across these categories, beneficiaries who received care in outpatient departments had higher average total spending than beneficiaries who received care in ASCs. The percent difference between outpatient and ASC total spending ranged from 13 percent for colonoscopy to 30 percent for ambulatory procedures, other. The methodology used to calculate these numbers already fully accounts for part-year Medicare enrollees and thus will not be revised.

In summary, patients and outpatient departments had both higher risk scores and higher total spending on average than patients in ASC's who received similar procedures. This indicates that outpatient departments serve patients who are more medically complex.

DR. MILLER: Ariel, can I just ask you one thing? I'm sorry to interrupt.

The last table, where you had the total expenditures there, that includes everything that goes to that patient. So it would include things like separate billings for radiological procedures or prosthetics or that kind of thing; is that correct?

MR. WINTER: That's right, as well as any other services they received besides ASC or outpatient services.

MR. HACKBARTH: This is their total utilization, on average, for the year.

MR. WINTER: That's correct.

MR. HACKBARTH: So it's another way of getting at the relative risk of the ASC versus outpatient department patients.

DR. NELSON: Does it include the copayment, as well? Does it include the patient contributions?

MR. WINTER: I believe it just includes the Medicare portion of the patient.

DR. REISCHAUER: Not to complicate this any further or make this into a real research job, but the geographic distribution of ASCs was very skewed. Is this at national prices? Or is this at --

MR. WINTER: This is at nationally standardized prices, yes. That's a good point.

This is the same recommendation you saw last month with a slight revision. We've added the clause in the beginning that until the secretary implements a revised ASC payment system -- and the rest of it is the same as what you saw last time -- Congress should ensure that payment rates for ASC procedures do not exceed hospital outpatient PPS rates for those procedures.

The reason we added this is because we believe that once the ASC payment system is revised, based on updated cost data, the disparities between ASC and outpatient hospital rates should be minimized.

We estimate that this recommendation would reduce spending in the category of between \$50 million and \$200 million in fiscal year 2000 and in the category of between \$250 million to \$1 billion between 2004 and 2008.

There are several concerns that have been raised about this recommendation, which I'll try to briefly address. The first is that outpatient departments receive additional payments, such as outlier and pass-through payments, that ASCs do not.

We would like to look into the issue of what types of procedures receive outlier payments, which represent about 2 percent of the total payments.

On the question of pass-through payments, most pass-through items have been incorporated into the base rates for 2003 so we believe this will be less of an issue going forward.

A second concern is that outpatient departments may be billing separately for radiology services that are provided ancillary to surgical procedures which ASCs cannot do. This is another issue we're looking into. We would note that we have learned that ASCs can bill separately for prosthetic devices which outpatient departments cannot do, they cannot bill for them

separately. They're currently bundled into the outpatient rate. So some of the unbundling also occurs on the ASC side.

A third concern is that outpatient rates may not cover costs as the procedural level and thus it would be inappropriate to apply them to ASC services. We believe that the 2003 outpatient PPS rates are the most accurate that can be calculated using current data. This year is the first time that the rates are based on the costs of hospitals operating under the outpatient PPS. In addition, they are more accurate than previous rates because most of the pass-through items have been folded into the base rates. If there are anomalies where outpatient rates do not cover costs, the secretary could deal with this during the rulemaking process that would follow a legislative change. For example, in anomalous situations he could decide to phase in payment reductions over time.

A fourth concern is that outpatient rates have been fluctuating from year to year. We expect that with incorporation of most pass-through items into the base rates, the rates should stabilize.

We estimated the impact of this recommendation using a model based on 2003 ASC and outpatient payment rates and 2001 volume of ASC services. Based on this model, we estimate that this recommendation would lower payment rates for half of the volume of ASC procedures accounting for 35 percent of Medicare payments. For these affected procedures the average payment reduction would be 20 percent. Overall, ASC payments would be reduced by about 7 percent and beneficiary coinsurance would also be reduced on average by about 7 percent.

This table shows the impact of the recommendation by procedure category for the categories with the highest share of Medicare payments to ASCs in 2001. Cataract removal, which accounts for half of the payments to ASCs, would be unaffected because ASC rates are currently lower than outpatient rates for these procedures.

The impact individual ASCs would vary by the services they offer and the share of their revenues accounted for by Medicare. About half of ASCs offer ophthalmology services and 40 percent offer gastroenterology services. About half of ASCs are single specialty and the other half offer multiple specialties.

The largest ASC chains report that Medicare accounts for 20 to 30 percent of their revenue. We don't have Medicare revenue data by specialty type across the entire industry but a large ASC firm has reported that Medicare accounts for 60 percent of its revenue for after cataract laser surgery, which is in the other eye procedures category on the table, and 30 percent of its revenues for colonoscopy and upper GI endoscopy, which also shown on the table there.

This concludes my presentation and I welcome your comments, questions, and look forward to your discussion.

MR. HACKBARTH: Could I just explore recommendation three for just a second to make sure I understand the intent?

Sometimes we make recommendations that are basically formulaic, take this marketbasket index and subtract that number and you get a very specific result. Here, on draft recommendation three, the tone seems to me to be a little bit different. By that I mean we're not necessary suggesting to the secretary take this number from the hospital outpatient schedule, compare it to this number from the ASC, and go to this. We're recognizing that some adjustment, some degree of judgment, may be necessary to get a true apples-to-apples comparison.

So this is really a statement of policy direction that the commission is concerned about having different payment levels for the same service in different settings for fear that that will inappropriately influence the clinical decision-making process, as opposed to this is the right formula to do it.

MR. WINTER: That's correct. That's our intention here.

MS. DePARLE: That's not how I read it, Glenn.

DR. NEWHOUSE: That's not how I read it. This is a formula, pay the lesser of the two rates.

MR. WINTER: I think what we're --

DR. REISCHAUER: To ASCs, not to outpatients.

MS. DePARLE: ASC rates shall not exceed hospital outpatient rates. That's how I read it.

DR. MILLER: I think to describe where we are in the conversation, both from last month to this month and here, is our policy statement was that ASC payment rates should not exceed outpatient. And I think that is where we generally are.

There have been concerns expressed throughout our conversations about ourselves and from the outside world. And I think what we're trying to reach for here is that in implementing something like this, the secretary -- there can either be a flat statement in the law that says you will pay no more, or you could construct the law in a way -- and I realize this is a little bit more difficult and I'm not sure I have the words to say, this is what the payment rate should be, but the secretary should exercise some discretion in reaching that.

So for example, if the Secretary found for a given procedure some evidence that cost was unaccounted for because the bundles are not completely defined, the secretary might take that into account or take the policy in steps. I think that's what we're trying to say here. Is that about right?

MR. WINTER: Yes, that's right.

MS. BURKE: That's not what that says. Only to the extent that if it is your -- I mean, there are a variety of ways you could do this. One would be to say that on average, they shall not -- I mean, there are a number of things you could do in constructing what the rate looks like.

But if your intention is to literally leave it discretionary to the secretary to determine where it is and is not an absolute, that is it shall be no higher. You're suggesting that there be circumstances where it would be higher. Then this doesn't achieve that end, I don't believe.

MR. HACKBARTH: Let's try to agree on the intent first and then we can deal with the language, and maybe that will require coming back with some revised language.

The new issue for me, this discussion as opposed to last time, is that the bundles are not exactly the same. And my intent would not be to say well, you've got to treat them as though they're the same and just do a simple comparison of this number and that number.

The point that I think is important is that we strive to make an apples-to-apples comparison which will require some judgment on the part of the secretary. But once we have that apples-to-apples comparison the policy principle ought to be they we not pay more for the service rendered in an ASC than we would in the hospital outpatient department.

So that's what personally I would strive for. Do people agree with that or disagree?

MR. SMITH: Glenn, I think I agree with that although it would follow from that that it ought to work in reverse. If we get the bundles precisely calibrated so that we're doing apples-to-apples, then that we should pay whichever rate is lower in whatever setting it's delivered.

[Simultaneous discussion.]

DR. REISCHAUER: One aspect is the bundles. The other is the acuity or the severity of the outpatient. A third is the regulatory burden and other costs that we impose on one. And we have pretty good evidence that all of those go to the disadvantage of the outpatient hospital.

DR. NEWHOUSE: The other is which bundle do you standardize to? Do you standardize to the old outpatient bundle, or to the old ASC bundle.

MS. BURKE: Isn't this essentially what he's supposed to be doing? My concern is not where you want to go but this is where we ought to be getting, and they haven't gotten there yet. So it's not clear to me how this would get you where you want to get before you get there.

[Laughter.]

DR. REISCHAUER: The question is does it move us in the right direction?

MS. BURKE: I'm sure that's what I meant. I'm sure of it.

[Laughter.]

MS. BURKE: My concern is that with that kind of specificity, that is what is supposed to occur in the context of building a payment system which they have not done. So are we again putting forward a proposal which from a policy perspective makes absolute sense, practically is the job that's supposed to have been done. And this suggests that in the absence of a revision of a system, do this.

My concern is this is what they ought to be doing to get to the system. So it's not clear to me how this happens before the work that has to be done in order to get to where ultimately we need to be. That would be my practical concern.

MR. HACKBARTH: I think there are two parts to what we're recommending here. The first recommendation is that we think this system needs to be revamped and we need to get on with it, and I think we have said or should say that the amount we pay for the same service in these two different settings needs to be synchronized in a way that it currently, as we speak, is not.

So recommendation one is we need to get on with the task of an overall rehaul and synchronization of the payment system.

Then stepped two is what do we do in the interim? What we're suggesting is that the secretary, as quickly as possible, move to assure that we're not paying more for a comparable bundle of services in the hospital outpatient department than we would in the ASC.

DR. NEWHOUSE: I suggest that we add to the end of this, after accounting for the differences in the bundle of services covered. I think that fixes what I heard was the problem.

MS. DePARLE: I just think, if I can go back to we've discussed this extensively at the last two meetings and the staff have spent a lot of time talking to me about it, which I appreciate, and they've tried to be responsible. But I think your point, Joe, and what we're discussing right now gets to the place where they can't be responsive, which is that we don't have the data.

Unlike other areas we've been looking at Medicare costs and Medicare margins and we don't have that here. And that's going to be hard work and the agency does need to get going on it, starting with collecting the data. But to say that they can just go immediately to this and start changing bundles around, that doesn't work.

And so that's been my concern about this whole thing, is that, as opposed other areas, we just don't have the data. As I said, I think the staff have done a tremendous job of trying to collect proxies for things about adequacy, but we don't have it.

MR. HACKBARTH: The difference, Nancy, I think may be in one case we're talking about cost data which is a difficult process, requires time.

What we're suggesting here is they not look at cost data but payment data, which is easier to collect. It doesn't require industry surveys. They simply need to look at what Medicare is paying, what they are paying. And as an interim step strive to not pay more for the same service in an ASC.

MS. DePARLE: But that presumes that you've made a judgment about cost being adequate.

MR. HACKBARTH: Just to be clear, I am not presuming anything about costs. I'm saying that we ought not pay more for the same service delivered in ASCs as opposed to hospital outpatient departments, especially in view of the evidence that we have about the complexity of the patients served.

DR. NEWHOUSE: In other words, is what you're proposing that we would just the numbers we saw on the screen by a payment rate

for radiological services and prosthetic devices until we've made those numbers cover the same bundle and then we would compare?

MR. HACKBARTH: Right.

DR. NEWHOUSE: That seems, to me, fine.

DR. REISCHAUER: I can't imagine why the data isn't available for that.

DR. NEWHOUSE: We'd have to use it for one system or the other, where we have a separate payment rate for that service, and add it to the bundle where it doesn't exist.

MS. DePARLE: I don't know, and I don't think any of us knows -- Mark, you may know -- how difficult it will be to unbundle and rebundle and make those comparisons about what's in the payment rates.

But I guess I don't quite follow, Glenn, what you're saying because I still think it does -- implicit in this discussion is some decision about a policy choice about adequacy of payments. I agree and have always agreed that we should not, through our payment methodology, favor one site of service over another for the same service unless there is some independent policy choice being made based on safety, efficacy, some other thing. But I just think we're fooling ourselves if we think this is going to get there.

DR. NELSON: This all presupposes that they are the same service. You might do an operation, the same operation, at two different sites and they may be totally different services. And we're trying to graft one payment system on another, and we're doing it arbitrarily by lopping the top of the other one.

It seems to me that we have always said that we should pay the legitimate costs of an efficient provider. For this service, we then need the data before we can do that. And we have all of these other confounding variables that we're ignoring to make an arbitrary decision to remove a portion of payments if they're high, but not bring up any if they're low.

My point on this is that it seems to me that beneficiaries benefit from having a choice. They benefit by having a lower copay in many instances if they go into an ambulatory surgical center. That they are not exactly the same services. And until we have data, I'm reluctant to make a recommendation that just sort of well, we'll peel off the top if they're paying higher. They're different services in many cases.

DR. REISCHAUER: But there's a perception...

MR. MULLER: I thought Ariel's presentation was quite convincing, in terms of both the complexity of care, in terms of the patients being more complex. He had at least two measures of that. And secondly, the regulatory burden, whether it's MTAL or other things one wants to cite.

So the argument, as I understand it, is that both the complexity is greater -- maybe not on every last received, but the complexity is greater on average in the outpatient setting. And the regulatory burden is greater in the outpatient setting. So there wouldn't be much reason for there to be a higher payment

in the ASC setting. And that's why, I think, the recommendation as written is well stated.

I think for the reasons that Nancy and Joe and others discussed once we start getting into exactly what kind of bundled services, I think that takes a more complex calculation to do. So I'm not as convinced of adding on the bundling language because I'm not sure we know what we're bundling vis-a-vis each other.

But certainly on the procedures, we have no reason to think that the ASC costs should be higher, and therefore are worthy of a higher payment.

DR. NELSON: We don't know.

MR. MULLER: We do know that the complexity is greater based on the information that Ariel presented. And we do know the regulatory burden is greater. That we do know.

MR. HACKBARTH: Any other comments on this? Why don't we go ahead and vote then. Recommendation one, do you want to put that up, Ariel?

All in favor of recommendation one?

Opposed?

Abstain?

Recommendation two. All in favor?

Opposed?

Abstain?

And recommendation number three, All in favor?

DR. REISCHAUER: With the modification?

MR. HACKBARTH: Good question. Actually, maybe the thing to do is ask, Ariel, for you to come back with a revision of the language so that we don't muddle around with it right now. Can you do that?

MR. WINTER: [Nodding affirmatively.]

MR. HACKBARTH: Do you have any questions about the intent?

MR. WINTER: I was going to use Joe's suggestion.

MS. RAPHAEL: Could you just read it for us?

MR. WINTER: Sure. It would read, under Joe's modification, until the secretary implements a revised ASC payment system, the Congress should ensure that payment rates for ASC procedures do not exceed hospital outpatient PPS rates for those procedures after accounting for differences in the bundle of services covered.

MR. HACKBARTH: Are people prepared to vote right now on that? All in favor?

Opposed?

Abstain?

Okay, thanks, Ariel.